Nursing Home Conditions in the 2nd Congressional District of Colorado: Many Homes Fail to Meet Federal Standards for Adequate Care

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EXECUTIVE SUMMARY

Many families are becoming increasingly concerned about the conditions in nursing homes. Federal law requires that nursing homes "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." But recent studies by the U.S. General Accounting Office and others have indicated that many nursing homes fail to meet federal health and safety standards.

To address these growing concerns, Rep. Mark Udall asked the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in the 2nd Congressional District of Colorado, which includes Boulder and the northern suburbs of Denver. There are 27 nursing homes in the Rep. Udall's district that accept residents covered by Medicaid or Medicare. These homes serve approximately 2,400 residents. This is the first report to evaluate their compliance with federal nursing home standards.

The report finds that there are serious deficiencies in many of the nursing homes in Rep. Udall's district. Only eight of the nursing homes in the district were in full or substantial compliance with federal standards during their most recent annual inspection. In contrast, 70% of the nursing homes in the 2nd Congressional District of Colorado had violations that had the potential to cause more than minimal harm or worse. Moreover, 15% of the nursing homes -- one out of every seven -- had violations that caused actual harm to residents.

A. Methodology

Under federal law, the U.S. Department of Health and Human Services contracts with the states to conduct annual inspections of nursing homes. These inspections assess whether nursing homes are meeting federal standards of care, such as preventing residents from developing pressure sores (commonly known as bed sores), providing sanitary living conditions, and protecting residents from accidents. State inspectors are instructed to rate the scope and severity of each violation. There are four general categories of violations: (1) violations that have the potential for only minimal harm; (2) violations that have the potential for more than minimal harm; (3) violations that cause actual harm; and (4) violations that cause actual death or have the potential to cause death or serious injury.

This report is based on an analysis of the most recent annual inspections of nursing homes in the Rep. Udall's district. These inspections were conducted from February 1999 to February 2000. When a nursing home was reported to have serious violations, the report also examined the results from the prior round of inspections to assess the home's compliance history.

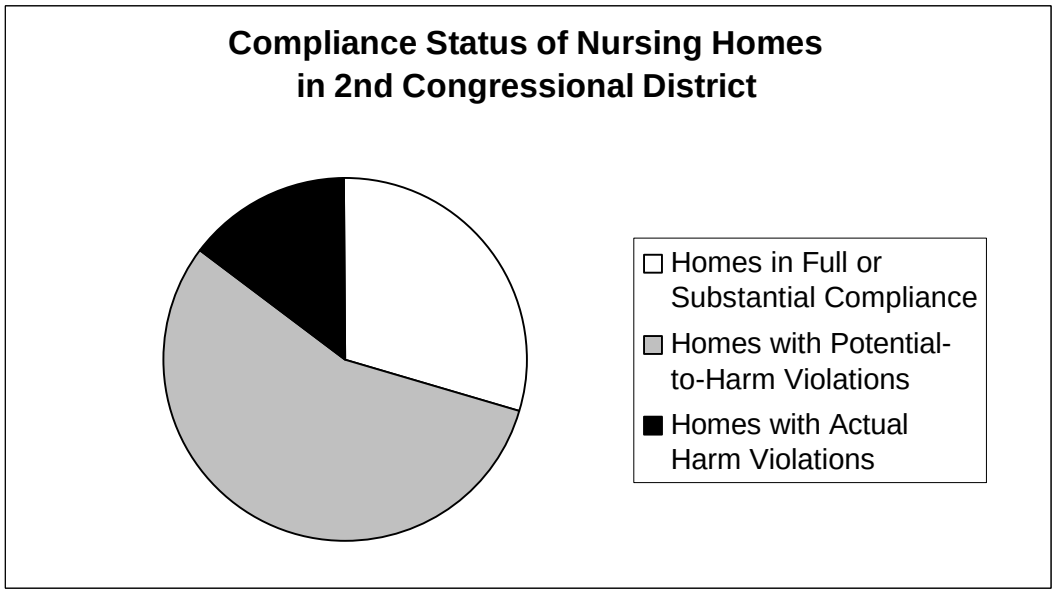
Because this report is based on recent annual inspections, the results are representative of current nursing home conditions in the district as a whole. However, conditions in individual homes can change. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden deterioration. For this reason, the report should be considered a representative "snapshot" of overall conditions in nursing homes in Rep. Udall's district, not an analysis of current conditions in any specific home. Conditions could be better -- or worse -- at

any individual nursing home today than when the most recent annual inspection was conducted.

B. Findings

Many nursing homes in the 2nd Congressional District of Colorado violate federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal standards if no violations are detected during the annual inspection. They will consider a home to be in "substantial compliance" with federal standards if the violations at the home do not have the potential to cause more than minimal harm. Of the 27 nursing homes in the district, only eight homes (30%) were found to be in full or substantial compliance with the federal standards. Nineteen nursing homes (70%) had at least one violation with the potential to cause more than minimal harm to residents or worse. On average, each of these 19 nursing homes had four violations of federal quality of care requirements.

Several nursing homes in the 2nd Congressional District of Colorado have violations that cause actual harm to residents. Of the 27 nursing homes in the district, four homes (15%) had a violation that caused actual harm to nursing home residents (see Figure 1). These four homes serve 411 residents and are estimated to receive $3.8 million each year in federal and state funds.



An examination of the homes with significant violations showed serious care problems. Representatives of nursing homes argue that the "overwhelming majority" of nursing homes meet government standards and that many violations causing actual harm are actually trivial in nature. To assess these claims, this report examined in detail the inspection reports from the 19 homes that were not in full or substantial compliance with federal standards. The inspection reports documented that the actual harm violations cited by state inspectors were for

serious neglect and mistreatment of residents, including one violation that led to the death of a resident. Moreover, the inspection reports documented many other violations that would be of great concern to families, but were not classified as causing actual harm, indicating that serious deficiencies can exist at nursing homes cited for potential-to-harm violations.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

Increasingly, Americans are facing difficult decisions about nursing homes. The decision to move a loved one into a nursing home raises very real questions about how the resident will be treated at the nursing home. Will the resident receive proper food and medical treatment? Will the resident be assisted by staff with basic daily activities, such as bathing and dressing? Will the resident be able to live out his or her life with dignity and compassion? These are all legitimate concerns -- and they are becoming more common as America ages.

In 1966, there were 19 million Americans 65 years of age and older.[1] That figure has now risen to 34.6 million Americans, or 13% of the population.[2] In 25 years, the number of Americans aged 65 and older will increase to 62 million, nearly 20% of the population.[3]

This aging population will increase demands for long-term care. There are currently 1.6 million people living in almost 17,000 nursing homes in the United States.[4] The Department of Health and Human Services (HHS) has estimated that 43% of all 65 year olds will use a nursing home at some point during their lives.[5] Of those who do need the services of a nursing home, more than half will require stays of over one year, and over 20% will be in a nursing home for more than five years. The total number of nursing home residents is expected to quadruple from the current 1.6 million to 6.6 million by 2050.[6]

Most nursing homes are run by private for-profit companies. Of the 17,000 nursing homes in the United States, over 11,000 (65%) are operated by for-profit companies. In the 1990s, the nursing home industry witnessed a trend toward consolidation as large national chains

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[1]Health Care Financing Administration, *Medicare Enrollment Trends, 1966-1998* (available at http://www.hcfa.gov/stats/enrltrnd.htm).

[2]U.S. Census Bureau, *Resident Population Estimates of the United States by Age and Sex: April 1, 1990 to August 1, 1999* (Oct. 1, 1999).

[3]U.S. Census Bureau, *Resident Population of the United States: Middle Series Projections, 2015 - 2030, by Age and Sex* (March 1996).

[4]Testimony of Rachel Block, Deputy Director of HCFA's Center for Medicaid, before the Senate Special Committee on Aging (June 30, 1999).

[5]HCFA Report to Congress, *Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System*, §1.1 (July 21, 1998).

[6]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, 5 (1999).

bought up smaller chains and independent homes. The five largest nursing home chains in the United States operated over 2,000 facilities and had revenues of nearly $14 billion in 1998.[7]

Through the Medicaid and Medicare programs, the federal government is the largest payer of nursing home care. Under the Medicaid program, a jointly funded, federal-state health care program for the needy, all nursing home and related expenses are covered for qualified individuals. Under the Medicare program, a federal program for the elderly and certain disabled persons, skilled nursing services are partially covered for up to 100 days. In 2000, it is projected that federal, state, and local governments will spend $58.1 billion on nursing home care, of which $44.9 billion will come from Medicaid payments ($27.7 billion from the federal government and $17.2 billion from state governments) and $11.2 billion from federal Medicare payments. Private expenditures for nursing home care are estimated to be $36 billion ($29.2 billion from residents and their families, $5 billion from insurance policies, and $1.8 billion from other private funds).[8] The overwhelming majority of nursing homes in the United States receive funding through either the Medicaid program or the Medicare program, or both.

Under federal law, nursing homes that receive Medicaid or Medicare funds must meet federal standards of care. Prior to 1987, these standards were relatively weak: they focused on a home's ability to provide adequate care, rather than on the level of care actually provided. In 1986, a landmark report by the Institute of Medicine found widespread abuses in nursing homes.[9] This report, coupled with national concern over substandard conditions, led Congress to pass comprehensive legislation in 1987 establishing new standards for nursing homes. This law required nursing homes to "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[10]

Implementing regulations were promulgated by HHS in 1990 and 1995. The 1987 law and the implementing regulations limit the use of physical and chemical restraints on nursing home residents. They require nursing homes to prevent pressure sores, which are painful wounds or bruises caused by pressure or friction that can become infected. They also establish other safety

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[7]Thomas J. Cole, *Awash in Red Ink,* Albuquerque Journal, A1 (Aug. 3, 1999).

[8]All cost projections come from: HCFA, *Nursing Home Care Expenditures and Average Annual Percent Change, by Source of Funds: Selected Calender Years 1970-2008* (available at http://www.hcfa.gov/stats/NHE-Proj/proj1998/tables/table14a.htm).

[9]Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (1986). The IOM report concluded: "individuals who are admitted receive very inadequate -- sometimes shockingly deficient -- care that is likely to hasten the deterioration of their physical, mental, and emotional health. They are also likely to have their rights ignored or violated, and may even be subject to physical abuse." *Id.* at 2-3.

[10]42 U.S.C. 1396r(b)(2).

and health standards for nursing homes, such as requiring that residents are properly cleaned and bathed, receive appropriate medical care, and are supervised to prevent falls and accidents. The regulatory requirements are codified at 42 C.F.R. Part 483.

Recently, investigators have begun to examine whether nursing homes are meeting the requirements of the 1987 law and its implementing regulations. The results have not been encouraging. Certain abusive practices documented by the Institute of Medicine in 1986, such as the improper use of physical restraints and anti-psychotic drugs, have been reduced.[11] But health and safety violations appear to be widespread. In a series of recent reports, the U.S. General Accounting Office (GAO), an investigative arm of Congress, found that "more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury";[12] that these incidents of actual harm "represented serious care issues ... such as pressure sores, broken bones, severe weight loss, and death";[13] and that "[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months."[14]

Other researchers have reached similar conclusions. In July 1998, Professor Charlene Harrington of the University of California-San Francisco, a leading nursing home expert, found that the current level of nursing home staffing is "completely inadequate to provide care and supervision."[15] In March 1999, the Inspector General of HHS found an increasing number of serious deficiencies relating to the quality of resident care.[16] And in September 1999, the Coalition to Protect America's Elders concluded: "Every day, thousands of frail elderly

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[11]The percent of residents in physical restraints dropped from 38% in 1987 to 15% in 1998; the percent of residents being administered anti-psychotic drugs dropped from 33% to 16% during the same time period. Testimony of Michael Hash, Deputy Administrator of HCFA, before the Senate Special Committee on Aging (July 28, 1998). Despite this progress, the improper use of physical and chemical restraints continues to be a problem at some nursing homes, as documented in part IV of this report.

[12]GAO, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 3 (March 1999).

[13]GAO, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, 2 (June 1999).

[14]GAO, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, 2 (March 1999).

[15]Testimony of Charlene Harrington before the Senate Special Committee on Aging (July 28, 1998).

[16]HHS Office of Inspector General, *Nursing Home Survey and Certification* (Mar. 1999).

Americans are endangered by nursing home abuse and neglect that have reached epidemic proportions."[17]

In light of the growing concern about nursing home conditions, Rep. Mark Udall asked the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in nursing homes in the 2nd Congressional District of Colorado, which includes Boulder and the northern suburbs of Denver. This report presents the results of this investigation. It is the first report to comprehensively investigate nursing home conditions in Rep. Udall's district.

II. METHODOLOGY

To assess the conditions of nursing homes in Rep. Udall's district, this report analyzed two sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; and (2) actual state inspection reports from a sample of 19 nursing homes.

A. Analysis of the OSCAR Database

Operating through the Health Care Financing Administration (HCFA), which administers the federal Medicaid and Medicare programs, HHS contracts with states to conduct annual inspections of nursing homes. During these inspections, the inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal standards observed by the inspectors are cited by the inspection team, reported by the states to HCFA, and compiled in the OSCAR database.[18]

HCFA has established a ranking system in order to identify the violations that pose the greatest risk to residents. This ranking system is used by state inspectors, and the rankings are included in the OSCAR database. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation. As shown in Table 1, each violation is given a letter rank, A to L, with A being the least serious (an isolated

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[17]Coalition to Protect America's Elders, *America's Secret Crisis: The Tragedy of Nursing Home Care*, 6 (Sept. 14, 1999).

[18]In addition to tracking the violations at each home, the HCFA database compiles the following information about each home: the number of residents and beds; the type of ownership (*e.g.*, for-profit or nonprofit); whether the home accepts residents on Medicare and/or Medicaid; and the characteristics of the resident population (*e.g.*, number of incontinent residents, number of residents in restraints). To provide public access to this information, HCFA maintains a website (http://www.medicare.gov/nhcompare/home.asp) where the public can obtain data about individual nursing homes.

violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Homes with violations in categories A, B, or C are considered in "substantial compliance" with the law. Homes with violations in categories D, E, or F have the potential to cause "more than minimal harm" to residents. Homes with violations in categories G, H, or I are causing "actual harm" to residents. And homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

Table 1: HCFA's Scope and Severity Grid for Nursing Home Violations

Severity of Deficiency	**Scope of Deficiency**		
	Isolated	*Pattern of Harm*	*Widespread Harm*
Potential for Minimal Harm	A	B	C
Potential for More Than Minimal Harm	D	E	F
Actual Harm	G	H	I
Actual or Potential for Death/Serious Injury	J	K	L

This report analyzed the results, as reported in the OSCAR database, of the most recent state inspections of each nursing home in Rep. Udall's district. These inspections were conducted between February 1999 and February 2000. Following the approach used by GAO in its reports on nursing home conditions, this report focused primarily on violations ranked in category G or above. These are the violations that cause actual harm to residents or have the potential to cause death or serious injury.

In cases where nursing homes were reported to have violations causing actual harm to residents in the most recent inspection, the report also analyzed the results of the previous inspection of the nursing home. This analysis was undertaken to assess whether there was a pattern of noncompliance at nursing homes in the 2nd Congressional District of Colorado.

B. Analysis of State Inspection Reports

In addition to analyzing the data in the OSCAR database, this report analyzed a sample of the actual inspection reports prepared by state investigators surveying nursing homes in Rep. Udall's district. These inspection reports, prepared on a HCFA form called "Form 2567," contain the inspectors' documentation of the conditions at the nursing home.

The minority staff selected for review the inspection reports of each of the 19 nursing homes in the district that were cited for either potential for more than minimal harm violations or actual harm violations. For each of these homes, the most recent state inspection report was obtained from the Colorado Department of Public Health and Environment. These reports were then reviewed to assess the severity of the violations documented by the state inspectors.

C. Interpretation of Results

The results presented in this report are representative of current nursing home conditions within the 2nd Congressional District of Colorado as a whole. In the case of any individual home, however, current conditions may differ from those documented in the most recent annual inspection report, especially if the report is more than few months old. Nursing home conditions can change over time. New management or enforcement activities can rapidly improve conditions; other changes can lead to sudden deterioration. According to GAO, many nursing homes with serious deficiencies exhibit a "yo-yo pattern" of noncompliance and compliance: after a home is cited for deficiencies, it briefly comes into compliance to avoid fines or other sanctions, only to slip into noncompliance after the threat of sanctions is removed.[19]

For this reason, this report should be considered a representative "snapshot" of nursing home conditions in the district. It is not intended to be -- and should not be interpreted as -- an analysis of current conditions in any individual nursing home.

III. NURSING HOME CONDITIONS IN THE 2ND CONGRESSIONAL DISTRICT OF COLORADO

There are 27 nursing homes in the 2nd Congressional District of Colorado that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 2,883 beds that were occupied by 2,421 residents during the most recent round of inspections. The majority of these residents, 1,354, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 175 residents. Eighteen of the 27 nursing homes (67%) in the district are private for-profit nursing homes.

The results of this investigation indicate that the conditions in these nursing homes often fall substantially below federal standards. Many residents are not receiving the care that their families expect and that federal law requires.

A. Prevalence of Violations

State inspectors found that less than one out of every three nursing homes in Rep. Udall's district was in full or substantial compliance with federal standards of care. Only six of the 27 nursing homes (22%) met all federal requirements during the inspections. Two other nursing homes (7%) were in substantial compliance with federal standards, meaning that they had no deficiencies that posed more than a minimal risk of harm.

The rest of the nursing homes in the district -- 19 out of 27 -- had at least one violation that had the potential to cause more than minimal harm or worse to their residents. Four homes

[19]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 12, at 12-14.

had violations that caused actual harm. Table 2 summarizes these results.

Table 2: Nursing Homes in the 2nd Congressional District of Colorado Have Numerous Violations that Place Residents at Risk

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	6	22%	290
Substantial Compliance (Risk of Minimal Harm)	2	7%	189
Potential for More than Minimal Harm	15	55%	1,531
Actual Harm to Residents	4	15%	411
Actual or Potential Death/Serious Injury	0	0%	0

Many nursing homes had multiple violations. During the most recent annual inspections, state inspectors found a total of 77 violations in homes that were not in complete or substantial compliance with federal requirements, or an average of four violations per noncompliant home.

B. Prevalence of Violations Causing Actual Harm to Residents

According to GAO, some of the greatest safety concerns are posed by nursing homes with violations that cause actual harm to residents. These are homes with violations ranked at G-level or higher. As shown in table 2, four nursing homes (15%) in the 2nd Congressional District had violations that fell into this category. These four homes are estimated to receive $3.8 million in federal and state funds each year.

C. Potential for Underreporting of Violations

The analysis of the prevalence of nursing home violations in this report was based on the data reported to HCFA in the OSCAR database. According to GAO, even though this database is "generally recognize[d] ... as reliable," it may "understate the extent of deficiencies."[20] One problem, according to GAO, was that "homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations."[21] A second problem was that when GAO inspectors accompanied state inspection teams, they found that the state inspectors sometimes missed significant violations, such as unexplained weight loss by residents and failure to prevent pressure sores.[22]

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[20]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 12, at 30.

[21]GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 4 (July 1998).

[22]*Id.* at 18-19. Federal inspectors also independently inspect a select number of nursing homes after states have completed their inspections. A recent GAO report found that in 69% of

Consequently, it is possible that the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. DOCUMENTATION OF VIOLATIONS IN THE INSPECTION REPORTS

Representatives for the nursing home industry have alleged that the actual harm violations cited by state inspectors are often insignificant. The American Health Care Association (AHCA), which represents for-profit nursing homes, has stated that the "overwhelming majority of nursing facilities in America meet or exceed government standards for quality."[23] AHCA also claims that deficiencies cited by inspectors are often "technical violations posing no jeopardy to residents" and that the current inspection system "has all the trademarks of a bureaucratic government program out of control."[24] As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute a serious deficiency.[25]

At the national level, these assertions have proven to be erroneous. In response to AHCA's criticisms, GAO undertook a review of 201 random actual harm violations from 107 nursing homes around the country. GAO found that nearly all of these deficiencies posed a serious harm to residents. Of the 107 homes surveyed, 98% were found to have a deficiency that caused actual harm, including "pressure sores, broken bones, severe weight loss, burns, and

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the instances in which this follow-up federal inspection was conducted, federal inspectors found more serious deficiencies than the state inspectors had found. GAO, *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, 9 (Nov. 1999).

[23]Statement of Linda Keegan, Vice President, AHA, regarding Senate Select Committee on Aging Forum: "Consumers Assess the Nursing Home Initiatives" (Sept. 23, 1999).

[24]AHCA Press Release, *AHCA Responds to Release of General Accounting Office Study on Enforcement* (March 18, 1999).

[25]Letter from Sen. Charles E. Grassley to William Scanlon, GAO, 1, May 27, 1999.

death."[26] GAO found that many of the deficiencies affected multiple residents.[27]

This report undertook a similar analysis at the local level. To assess the severity of violations in nursing homes in Rep. Udall's district, the minority staff examined the state inspection forms for the 19 noncompliant homes in the 2nd Congressional District of Colorado. These inspection forms contained numerous examples of neglect and mistreatment of residents.

One of the most disturbing findings from the review of the inspection reports was that the serious violations were not limited to violations cited at the G-level and above. To the contrary, many of the violations classified as having a "potential for more than minimal harm" (violations at the D, E, or F levels) involved conditions and mistreatment that would be regarded by most families of residents as unacceptable. The severity of these violations indicates that serious deficiencies can exist even at nursing homes that are not cited for actual harm violations.

The following discussion summarizes examples of the potential-to-harm and actual harm violations documented in the inspection reports reviewed by the minority staff.

A. Failure to Prevent Falls and Accidents

The failure to protect residents from falls and other accidents was a common violation documented in the state inspection reports. These violations are serious because falls and other accidents can result in severe injuries, including death.

In one case, a 91-year-old resident who was confined to a wheelchair rolled down a flight of twelve stairs while strapped into her wheelchair. The resident suffered forehead and facial lacerations, a closed head injury, blunt chest trauma, blunt abdominal trauma, a chipped vertebra, a rib fracture, and a fractured wrist. Approximately one month later, the resident died due to "delayed effects of traumatic injuries sustained in [the] fall."[28]

At another home, state inspectors found that the facility had allowed a resident to fall and

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[26]GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 13, at 2. A subsequent GAO study in September 1999 examined several examples provided by AHCA of serious deficiencies cited by state inspectors that AHCA asserted were of questionable merit. For those deficiencies which it had sufficient facts to analyze, GAO concluded that the regulatory actions taken against these homes were merited. Releasing these GAO findings, Senator Grassley, the chairman of the Senate Special Committee on Aging, stated: "The nursing home industry challenged the credibility of nursing home inspectors. The nursing home industry, after this challenge, lost." Congressional Record, S10745 (Sept. 13, 1999).

[27]GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 13, at 6.

[28]HCFA Form 2567 for Nursing Home in Longmont (Feb. 24, 2000) (G-level violation).

injure herself at least 24 times over a seven-month period, resulting in multiple trips to the emergency room for lacerations, head wounds, and other injuries. The inspectors even observed the resident falling several times during their inspection, but these falls were not recorded in the patient's records.[29]

At yet another home, the staff did not adequately monitor a 78-year-old resident suffering from Alzheimer's disease, allowing her to wander away from the facility on two occasions. The first time, she was found a mile away near a major urban intersection. Five months later, she climbed over a fence surrounding the facility's patio area and was found two miles away at a grocery store.[30]

B. Failure to Provide Proper Sanitation and Medical Care

Federal standards require that nursing homes provide residents with "the necessary services to maintain good . . . grooming and personal and oral hygiene."[31] Federal standards also require that nursing homes meet basic standards of sanitation and cleanliness. These standards reflect the expectations of families that residents will be properly cared for and cleaned. The inspection reports documented, however, that even this basic level of care was not being provided in many nursing homes.

Some homes were filthy and unsanitary. For example, inspectors described residents' rooms as "odorous," with toilets, walls, and floors stained, sticky, and covered with urine.[32] At another home, fecal matter was found on the floor near a resident's bed. When family members complained and even offered to clean up the fecal matter, the staff told them that it was "contaminated" and that they would have to do it. Nevertheless, the fecal matter was not removed for two full days.[33]

At one home, inspectors observed a resident who was left in soiled pants, "odorous of

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[29]HCFA Form 2567 for Nursing Home in Wheat Ridge (Feb. 10, 2000) (D-level violation).

[30]HCFA Form 2567 for Nursing Home in Westminster (March 24, 1999) (G-level violation).

[31]42 C.F.R. §483.25(a)(3).

[32]HCFA Form 2567 for Nursing Home in Thornton (June 3, 1999) (E-level violation).

[33]HCFA Form 2567 for Nursing Home in Westminster (March 24, 1999) (E-level violation).

urine," for almost five hours.[34] At another home, residents told the state inspectors that they were regularly left in "soaking wet" diapers, making one resident feel "terrible . . . like crying." Another resident said, "It is a disgrace we have to beg for some assistance."[35] When the inspectors returned to that home three months later, they found a resident who had not been bathed for a month.[36]

In other cases, the nursing homes failed to provide proper medical care to residents. Nursing homes were cited for administering the wrong medications to residents,[37] overdosing residents with sedating medication,[38] and failing to provide residents with necessary medications.[39] At other homes, residents received improper treatment for pressure sores,[40] a resident who was depressed and threatening suicide did not receive a psychiatric evaluation for 42 days,[41] and residents experiencing severe weight loss did not receive necessary dietary assessments or nutritional supplements.[42]

C. Abuse of Residents

Inspectors found that one home failed to take appropriate steps to protect residents from an abusive resident with an 11-month history of attacking other residents. During this period, the resident was involved in 39 reported incidents of physical and verbal aggression, including: throwing hot chocolate and water pitchers at other residents, punching a female resident in the face, hitting another resident from behind with his fist, and verbally abusing, swinging at, spitting on, and threatening to kill other residents. In the most extreme instance, the abusive resident attacked a female resident, who suffered "hematomas to both eyes, [her] lip was black

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[34]HCFA Form 2567 for Nursing Home in Thornton (June 3, 1999) (D-level violation).

[35]HCFA Form 2567 for Nursing Home in Westminster (Feb. 2, 2000) (G-level violation).

[36]HCFA Form 2567 for Nursing Home in Westminster (May 25, 2000) (G-level violation).

[37]HCFA Form 2567 for Nursing Home in Boulder (Dec. 9, 1999) (D-level violation).

[38]HCFA Form 2567 for Nursing Home in Denver (May 17, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Westminster (July 23, 1999) (D-level violation).

[39]HCFA Form 2567 for Nursing Home in Wheat Ridge (Apr. 7, 1999) (D-level violation).

[40]HCFA Form 2567 for Nursing Home in Boulder (June 2, 2000) (D-level violation).

[41]HCFA Form 2567 for Nursing Home in Thornton (Mar. 8, 2000) (D-level violation).

[42]HCFA Form 2567 for Nursing Home in Denver (May 17, 2000) (G-level violation).

and blue, [and] both forearms had skin torn to the tendons."[43]

D. Improper Use of Restraints

One of the major objectives of the 1987 nursing home law was to end the improper use of physical and chemical restraints. Although progress has been made in this area, the inspection reports documented that improper restraints continue to be a problem. For example, at one home, a resident who was suffering from anxiety and depression was restrained in her wheelchair and frequently left "without anything to do." As a result of the improper physical restraint, the resident became increasingly depressed, began to lose her ability to feed herself, and sustained a significant weight loss.[44]

At another home, the state inspectors found that a resident suffering from Parkinson's disease was placed at risk of strangulation because of the improper application of a wheelchair waist restraint.[45]

E. Inadequate Staffing

An underlying cause of many violations at nursing homes is inadequate staffing. Inspectors discovered that one home had only one nursing assistant on duty to care for 40 residents in the unit. Staff at the facility told inspectors that the staffing levels were "dangerous" and as a result, residents "don't get the care they need to get." Inspectors found that the facility did not have enough staff "to assist residents with eating, oral care, bathing, necessary treatments, and necessary services, including toileting and changes following incontinence episodes." As a result, inspectors concluded that residents experienced "significant weight loss, poor oral hygiene, embarrassment and humiliation" and "were placed at risk for skin breakdown, infections, [and] delayed healing."[46]

V. CONCLUSION

The 1987 nursing home law was intended to stop abuses in nursing homes by establishing stringent federal standards of care. Although the law and its implementing regulations require appropriate standards of care, compliance by nursing homes has been poor. This report reviewed the OSCAR database and a representative sample of actual state inspection reports. The same

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[43]HCFA Form 2567 for Nursing Home in Northglenn (Apr. 10, 2000) (G-level violation).

[44]HCFA Form 2567 for Nursing Home in Denver (May 17, 2000) (G-level violation).

[45]HCFA Form 2567 for Nursing Home in Wheat Ridge (Sept. 16, 1999) (G-level violation) (this home has subsequently changed ownership).

[46]HCFA Form 2567 for Nursing Home in Westminster (Feb. 2, 2000) (H-level violation).

conclusion emerges from both analyses: many nursing homes in the 2nd Congressional District of Colorado are failing to provide the care that the law requires and that families expect.